emailed validation letter 3/8/10

# Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 3-5-10
Amount #885-

Ch# 11601

## I. IDENTIFICATION

Name: Hicks Golden Years Nursing Home

Address: 1901 W. Hwy. 90

City/County/Zip: Monticello, Wayne 42633

Telephone number: (606) 348-6034

Administrator: Darrell Hicks

Date facility operation began at current address: 12-6-77

Date facility began operation under current owner: 04-11-02

RECEIVED
MAR - 5 2010
OFFICE OF INSPECTOR GENERAL

## II. TYPE BEDS

| | No. beds licensed | No. beds requested |
|---|---|---|
| Skilled | | |
| Nursing Home | | |
| Nursing Facility | 59 | 59 |
| Intermediate Care | ~~59~~ | ~~59~~ |
| ICF/MR | | |
| Personal Care | | |

## II. CONTROL (check one in each column)

(State) / County / City / Private

(Profit) / Nonprofit

Individual / Partnership / (Corporation) LLC

## II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Hicks Enterprises of Monticello, LLC
1901 W. Hwy. 90
Monticello, Ky. 42633

(OVER)

11/30

If facility owned or leased by a corporation, complete the following:

Name of corporation Hicks Enterprises of Monticello, LLC.

Address of corporation 1901 W. Hwy. 90

President or Chairman Darrell Hicks

Vice President

Secretary Debbie Tucker

Treasurer

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

| Parent | Management Company |
|---|---|
| N/A | N/A |
| | |
| | |

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

| Signature of authorized representative | Title | Date |
|---|---|---|
| | adm | 3/3/2010 |

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

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(10/2002)